Dr. Robin Slowenko   Dr. Jason Kopchynski   Dr. Steven Arcand   Dr. Tijana Lazova

IV SEDATION REFERRAL FORM

PATIENT NAME: __________________________ **DOB (DD/MM/YYYY):** ____________

ADDRESS: ________________________________

____

EMAIL ADDRESS: ____________________@________________________

PHONE NUMBERS: Home: _______________ Work: _______________ Cell: _________________

INSURED BY: ____ (include Insurance Carrier, Group number and ID number)

*Please note: A Consultation is required before proceeding with any treatment. The Consultation Fee of $119.00 must be prepaid before the Consultation Appointment is scheduled. This may or may not be reimbursed by the patient's insurance provider.

TREATMENT REQUESTED: Please enclose complete treatment plan including radiographs and photos (any referrals sent without this information will be returned)

Current Medical Conditions: ____

Allergies: ____

List of Medications & Dosages: ____

____

____

Level of Anxiety: Mild Moderate Severe

Referring Clinic/Doctor: __________________________________ Phone Number: __________________

Gateway Mall 335-1403 Central Avenue Prince Albert, SK S6V 7J4 T: 306.764.4144 F: 306.764.5430
Cornerstone 720 – 800 - 15th Street East Prince Albert, SK S6V 8E3 T:306.764.4144 F:306.764.5438
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